36. *New Procedure for the Reduction of Dislocation of the Head of the Humerus beneath the Coracoid Process.* By M. A. SALMON.—This method, in which the slowness of the procedure is the principal characteristic, is founded upon the precept laid down by Dupuytren, viz., that in order to overcome muscular resistance, it is necessary to proceed with the greatest gentleness and precaution, and to persuade the patient that the operator's intention is merely to examine the injured joint.

The patient should lie down, the side on which the dislocation exists extending beyond the bed, the injured arm being supported by an assistant. The surgeon grasps the forearm and hand, and very slowly raises the limb from the side, discontinuing his efforts when the slightest pain is complained of, and gently chafing the muscles of the shoulder. This period of the operation may occupy from ten minutes to a quarter of an hour.

During this interval the dislocated arm is gradually moved from the body, and finally raised straight up to the head, when reduction may be easily accomplished in the following manner:—

The raised arm is intrusted to an assistant, who supports it without effort in its new position, while the surgeon, placing himself on the inner side of the limb, fixes the scapula by applying his hands over the shoulder, and with both thumbs gently pushes back the head of the bone into the glenoid cavity, slight traction being at the same time exercised, if necessary, by the person who holds the arm. The limb is restored to its natural position when the bone has been replaced. The operation is thus brought to a conclusion in a perfectly painless manner, and without the patient being even aware of the fact.—*Ranking's Abstract*, vol. xl., from *Journ. de Méd. et Chir. Prat.*, Nov. 1864.

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37. *Bony Anchylosis.*—Mr. B. E. BROADHURST read a paper on this subject before the Western Medical and Surgical Society (Dec. 2, 1864). He gave the details of a case of bony anchylosis of the hip-joint, in which the neck of the thigh-bone was cut through to form a false joint. Cases of bony anchylosis are rare. When of the hip-joint the patient is very helpless, and can only move by the aid of crutches. He is less helpless when any other joint is affected. The propriety of interfering with bony anchylosis of the knee or ankle-joint may be questioned, but in the case of the hip and the elbow-joint it is of great importance to give the patient a chance of renewal of motion, even where motion would seem to have been hopelessly lost. In operating it is important to divide the bone as near as possible to the articulation. In the elbow a wedge-shaped piece may be taken from the centre of the articulation; and in the hip the neck of the femur may be divided just below the head of the bone. The divided ends of the bone may then be scooped out, so that both surfaces shall be concave. There is difficulty in retaining motion in these cases, so strong is the tendency for bony union to occur. A swinging limb need never be feared. If the action of the muscles cannot be gained, reunion by bone is certain to take place. It is important, therefore, to divide the bone in the most favourable position for the action of the muscles, and that point must be the nearest possible point to the articulation itself. In these cases we have to deal with tolerably healthy structures, and hence it is that the tendency to repair is strong in them. The muscles, too, which formerly moved the limb are somewhat altered in structure, and through disuse they will have lost power. It will require, therefore, for a lengthened period both patience and fortitude to gain fair muscular power after bony anchylosis has once become fully established. *Case.*—A. M., aged 23 years, suffered from bony anchylosis of the left hip. When she was 10 years old she met with an accident, through which inflammation was excited. She continued to walk, however; no attention being paid to the limb for many months. She limped as she walked. The limb swelled; an abscess formed, and continued more or less to discharge pus, with portions of necrosed bone, for ten years. Pain and abscesses at length ceased, and the limb became motionless. The author first saw the patient in 1862; she was in fair health. The question simply was: Could motion be given? Anchylosis had taken place without dislocation of the head of the femur occurring. The neck of the bone was in part absorbed. The limb was shortened one inch and a-half. The pelvis was rendered oblique—

apparently increasing the shortness of the limb by two inches. She had during the previous year walked with crutches, and worn a boot which was raised three inches in the sole. The case appeared favourable for operation, and it was thus performed: An incision three inches long was made, commencing over the head of the femur, and passing to the outer side of the great trochanter; from the upper angle of which another incision extended inwards for two inches. The neck of the bone was divided, and the ends gouged out as before described. The flesh wound healed almost by the first intention. Movement of the limb was attempted when the cicatrix had formed, but it was difficult, and so painful, that without chloroform it could not have been borne. This passive motion was, however, continued, and at length the limb moved readily, and even some voluntary motion was gained, so that the patient could flex the limb to a right angle. After six months she could rotate the limb outwards, and sit down at ease. The pelvic obliquity was easily removed; the horizontal position being in itself almost sufficient for this purpose; and the foot was consequently brought by so much nearer to the ground. A steel support, with joints opposite to the hip, knee, and ankle, was fitted to the limb; and the buttock was supported by a leather shield. With this instrument, and a couple of sticks, the patient moved about easily. The operation has now been done two years. There is no lack of firmness about the hip-joint; but, on the contrary, it requires constant exercise to keep it free. The patient now walks without the instrument, and with one stick for support.—*Med. Times and Gazette*, Feb. 4, 1865.

38. *Lithotrity an Eminently Successful Operation.*—Mr. HENRY THOMPSON, Surgeon to University College Hospital, in order to show that lithotrity is an eminently successful operation, adduces (*Lancet*, Feb. 25, 1865) his own personal experience of the operation during the year 1864. He gives a brief statement of every case, nineteen in number, in which he has performed and completed lithotrity during that year.

"This list comprises eighteen adults, all relieved of stones, of which but a few were small. One patient only died, and certainly not as a direct result of lithotrity, but of renal disease and renal calculus, after having recovered from the primary effects of the operation. Of these eighteen adults, the youngest was forty-five years old, the eldest seventy-five years; the majority were above sixty-two years; four were seventy and upwards; and the average age of the whole number is also, as nearly as possible, sixty-two years. No one, I presume, will imagine that for these cases the operation of lithotomy would have afforded results in any way comparable; nevertheless many of the stones were of considerable size.

"I venture to add that, in my opinion, the success of lithotrity depends upon the method adopted. During a considerable period of the history of that operation its results were undoubtedly inferior to the results of lithotomy in average hands; and if the same method be still employed, no better results can be expected."

Mr. T. proposes at an early day to offer a few remarks on what appears to him to constitute the safe and successful practice of lithotrity.

39. *Irrigation in the Treatment of Penetrating Wounds of the Knee-Joint.*—Dr. WM. NEWMAN published in the *British Medical Journal*, for June 27th, 1857, an account of five cases of penetrating wounds of the knee-joint, successfully treated by irrigation, and in the No. of the same journal for Dec. 3d, 1864, he relates three more cases equally successfully treated by the same means.

"If cold," he observes, "be the appropriate remedy for any surgical affection, it is but a bare truism to maintain that it should be applied effectually. If this, then, is to be done in the case of some acute inflammation—of a joint, for example—the constant presence of an attendant will be imperative, who may apply thin coverings moistened with some frigorific or evaporating lotion to the part affected, and change these coverings at very frequent intervals, as they become either warm or dry. But to speak of such procedures as available or possible in everyday surgical practice would be absurd. How is cold, then, applied? Usually, a lotion is prescribed, and some material soaked in this is